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ABSTRACT

Possible long-term consequences of changes in the provision and financing of health programs and implications of "New Federalism" for child health care advocates are explored. Preliminary discussion focuses on general problems of resource scarcity, describing how the new awareness of scarcity affects thought patterns and attitudes. Reference is made to the manner in which the notion of scarcity is being used to buttress ideological agendas that are not tied to, and do not necessarily stem from, the perceived decline in America's economic growth. Discussion then turns to the uncertain character of the New Federalism. Largely pessimistic assumptions regarding likely outcomes of the evolving relationships between levels of government are identified; these assumptions point toward a gradual cutback, sorting out, and devolution of federal programs. Receiving particular attention is the changed role of child health care advocates in working to obtain funding, meeting needs for the acquisition and dissemination of information, and participating in the debate about the restructuring of intergovernmental relationships and responsibilities. Concluding remarks focus on five recommended lines of action, by which advocates can alter constraints under which they operate. (RH)

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"New Federalism": Prospects and Implications

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Paper prepared for the conference on State Action to Improve Child Health, Washington, D.C., May 5-7, 1982.

Introduction

This paper considers the possible long-term consequences of changes in responsibility for and financing of health programs and the implications of "New Federalism" for those concerned with child health. As is the case with a number of the topics and issues addressed in other papers before us, the specifics of child health must be placed in a broader context. While child health and child health programs have their own characteristics, they are also part of a larger whole. Child health is one of a number of health care programs, and health programs are part of the larger social service sector. Furthermore, that sector, part of the larger economy, is only one of the many arenas in which federal relationships are expressed. An understanding of possible future developments in the structuring of child health activities, therefore, requires consideratiaon of the possible dimensions of "New Federalism" and the nature of its thrust toward new ways of expressing federal, state, and local relationships.

Without that general examination, we would commit an error which I believe has often characterized policy discussions in the health field; indeed, perhaps in any applied field. That error has been to focus the discussion almost exclusively on the particular field and its special features and, in so doing, to underestimate important economic and social forces that are at play in the society and that impinge on the sector under examination. Too often, by stressing the unique characteristics of that with which the analyst is concerned and of that which he or she knows best, the policy discussion proceeds as if the applied area, say health care, is exempt from changes in prevailing values, attitudes, and ideologies.

Perhaps that is in the nature of intellectual specialization and compartmentalization. After all, each sector--say, child health and health care--has special features, and it is necessary to refer to and draw insights and consequences from those particular attributes. Who better than students of the applied field can do that? The general sociologist, political scientist, economist, social critic, or intellectual historian may fail to see the direct application of his or her discipline to child health or, seeing it, to note the inferences to be drawn and the exceptions to be noted. The applied field specialist, however, must take account of the fact that the organization, practice, and financing of services that he studies reflect the society in which they are found. It is necessary, therefore, that those of us who are thinking about future possibilities, constraints, and developments in health care consider the broader setting. We cannot behave as if our special concerns can be addressed in ways that are exogenous to our society or that are fundamentally at variance with "the climate of opinion."

These comments serve to explain what this paper will attempt to do. I shall examine the general problems of resource scarcity, discuss how the new awareness of scarcity impacts on thought patterns and attitudes, and refer to the manner in which the notion of scarcity is being used to buttress ideologic agendas that are not tied to and do not necessarily stem from the perceived decline in America's economic growth. Only then will I consider the nature of the thrust for new relationships between the federal and state governments and the possible implications for child health activities and federal and state

health programs. In doing so, I will be conscious of the fact that we are witness to a period of rapid change characterized by discontinuities. None of us can be certain about how President Reagan's "New Beginning" will end or about the kind of America in which our children and their children will live.

It is hardly necessary to stress that I shall range over and dip into areas that fall into various disciplines. I do so with the conviction that this is required. I also do so with hesitation. I am, at best, an observer of the scene, not a student or scholar versed in the various disciplines. My starting point and framework are economics. Others examining issues of federalism from a different disciplinary perspective would start elsewhere. Their frameworks would lead them to cast the argument differently and perhaps to reach different judgments. In raising what I hope will be the right questions, we will, however, be able to sharpen the discussion and, perhaps, build a better bridge between the general and the specific.

Attitudes and Ideology

Resource Scarcity

Those of us who enrolled in our first economics course during the immediate post-World War II period will surely remember the emphasis placed on explaining the need to make choices since, in a world of scarcity, we could not have as much as we desired of all the things we wanted or felt we needed. Almost in the first lecture, we were exposed to the "production possibility curve," a graphic representation of the need for choice (often expressed as "guns" or "butter.") While it, of course, was true that college students then--as now--lived on limited budgets and were well aware of their own strained resources, it was also true that those of us who taught economics found that we had to convince students that nations (even including the United States) faced--and would continue to face--limits. It took some convincing.

The depression, after all, was a thing of the past. The economy and incomes were growing. "Rising expectations" were a problem that, presumably, existed only in the lesser-developed countries. Surely, in the United States (excepting the problems created by the advertising industry), we had the ability to meet all expectations. The Other America of which Michael Harrington wrote as late as in 1962 was invisible. The vast majority of students saw themselves as part of a society in which an expanding present led to a fully satisfying future. For them, the issue was not how to share scarcity; the American economy would continue to create plenty. Automation would make so much available that hours of work would decline. The future was rosy; one in which everyone would have strawberries and cream. It was the sad lot of the economist to be called upon to deal with reality and, thus, forced to dispel myth, illusion, and fantasy.

Today, the world seems--and is--different. Ye shall know them by their books: The Affluent Society has been replaced with The Zero-Sum Society. Since economics continues to deal with the allocation of scarce resources, introductory courses still require elaboration of the concept of scarcity. But it no longer is necessary to convince students of the validity of the

concept. We are all aware of scarcity, accept it as a given, appreciate the significance of energy resources, and recognize some of the limits placed upon us by international competition. President Nixon was incorrect in suggesting that all of us are Keynesians, but all of us have become economists.

Years of Presidential speeches and statements about federal deficits have had their impact. We know that the federal government, too, has limited resources. Though borrowing enables it to spend what it has not received, there are economic and political consequences associated with deficit financing. We may not understand how interest rates are determined or the significance of such variables as the deficit, the savings rate, or the money supply, but we have come to accept the statement that government does not have the resources (at current levels of tax revenue) to do all the things it might want to do or that many of us believe need doing. We may be puzzled about what happened to the post-Vietnam fiscal dividend and may wonder why it is apparently no longer possible to support programs that were funded in an earlier period when we, as individuals, and the various levels of government were "poorer" than is the case today. Nevertheless, many of us have come to accept the notion that that is the peculiar world we live in.

Awareness of national resource scarcity and of the impoverishment of government has coincided with the growth of skepticism concerning the quality of the federal government's performance. Presidents tell us--and in doing so help create a self-fulfilling statement--that many Americans share a belief that, even if the government had additional resources with which to "do the job," it would not necessarily use those resources to address the right problems, would not know how to solve the problems it did address, and would not do so efficiently and effectively. Years of rhetoric about unresponsive government bureaucrats, about "throwing money at problems," about waste and fraud have had their impact. Scarcity means the government cannot do everything; cynicism suggests it cannot do anything.

It is surely not necessary to dwell on these matters. All of us recognize the changes in attitude that have occurred in the last decade and a half. We may differ on the contribution that various factors have made to our present state, on the importance to be attached to specific events, even on whether the changes are to be welcomed or deplored, but surely we agree that there are to be welcomed or deplored, but surely we agree that there have been changes, important changes, in attitudes toward the federal government s capabilities and responsibilities. These changes cannot help but have repercussions on the way Americans view the relationship and the division of tasks between and among the various participants in the enterprise, that is, the individual citizen and the various levels of government.

Whether justified or not, the loss of faith in government's abilities to solve (or, more modestly, to contribute to the solution of) domestic problems is real. This is a general issue and individuals working in the various applied areas, e.g., transportation, welfare, housing, can point out the particular ways that the change in perception impacts on the area of their responsibility and interest. The impact on the health care field has been particularly large, especially so because the sector has been characterized by

complex relationships, fuzzy boundaries as well as overlap between public and private, profit and not-for-profit, and the various levels of government. Furthermore, the fact that in many cases existing relationships and programs are of relatively recent vintage has added to the problem. The different levels of government, the private sector, and the citizen each have different concerns, responsibilities, goals, interests, and agendas. Thus, for example, though health care costs impact on all, the incentive and the leverage to address these costs differ.

At the federal level, the current Administration places a high priority on reducing federal expenditures for health care and the health-sector activities. This priority stems from the sheer size of federal expenditures for Medicare and Medicaid and, with stable service benefits, from the seemingly inexorable growth in these expenditures. The Administration has adopted an economic game plan that calls for a cut in federal income taxes together with an increase in defense expenditures. It uses the consolidated budget as its scorecard: thus, it has been forced (though not against its ideologic desires) to treat Social Security and Medicare, even in spite of their separate trust-fund funding, as part of its macroeconomic program. We have come a long distance from the time only two short decades ago when, during a recession, a different Administration was loath to postpone a scheduled Social Security tax rate increase lest it be accused of tampering with social insurance, of using the Social Security system for fiscal policy purposes. If, in trying to control expenditures, this Administration can "tamper" (and more than tamper) with Medicare benefits, how much easier it is to cut Medicaid and child health programs. The perceived need is to cut federal expenditures. If that means a reduction in government's efforts to provide a decent minimum even in the face of inequality, so be it--and, perhaps, from the ideologic perspective of some members of the Administration, so much the better.

The society's concern with health care has a rich history and has been expressed in many and diverse ways. Though we have seen shifts in the priority attached and attention directed to various health problems and population groups, we have--and for a long time--witnessed a trend toward a greater sharing of the costs of care and a more extensive definition of health care, education, and research as public goods. Today that trend is broken, perhaps reversed. The public-policy dialogue focuses increasingly, almost exclusively, on the rising costs of care and especially on their impact on federal expenditures. This preoccupation with costs and expenditures does not derive from an animosity to health. Were that the case, we could be optimistic for the issue would be how best to deal with a temporary aberration. The problem is made more secure because the emphasis on reductions is not unique to the health sector. It is built on a new awareness of scarcity and of limits. In this Administration, that public awareness serves as the rationale for measures that reflect a new and different attitude toward redistribution and toward the role of government. We face an environment in which government, the engine of redistribution, is defined as impoverished. It, presumably, no longer can allocate the resources required to fund redistributive programs at present real levels (i.e., adjusted for inflation).

Health care costs have been rising rapidly and have been absorbing an ever-increasing share of our Gross National Product (GNP). These higher expenditures have been associated with and have made possible increased access to health care services. But it is also true that a substantial portion of the increase in expenditures (a function of the kinds and quantities of services we utilize and their prices) is the consequence of the complex ways that we have chosen to finance health care in the United States. Another substantial portion derives from the application of new (and expensive) technologies. There is a growing recognition that not all of the increases in expenditures represent necessary costs incurrred in advancing the health status of the citizenry. There is an increasing understanding that, since the share of GNP absorbed by the health sector cannot continue to increase indefinitely, it is necessary to address questions of health care organization and costs. This requires that those of us who are concerned about equity advance meaningful actions to control expenditures. The failure to do so means, as the federal budget already reveals, that costs are likely to be controlled in ways that will do violence to equity considerations and to the concept of health care as a public good.

The current climate has enabled the Administration to exploit legitimate concerns about costs, building on the revenue-expenditures-deficit drama and on inflation in health insurance premiums to advance its ideologic agenda. The Administration's agenda is not simply to contain costs but to do so in particular ways. Since its desires are not limited exclusively to cost control, it is possible that even without a health cost "crisis" the Administration would treat funding for health care programs as it is being treated, that is, would attempt to reprivatize the sector and to shift costs onto patients. That agenda would still be there if we suddenly became "rich". Though the distinction in motivation may appear to be a nuance, I believe it is important. If the Administration's health care policy agenda is not shaped entirely by cost considerations, I suggest that it would be futile to attempt to convince the Executive branch that there are alternative solutions to cost containment. The opportunity costs involved in an exercise in futility are large.

While the Congress may react in a different manner, the Administration sees health care as an area in which to apply its views about the market and about federalism. Facts are not likely to dispel the desire to do so. Analysis of possible increases in inequality and in disparities are not likely to sway a President who in his January 19, 1982, news conference offered an amplification of the "love it or leave it" theme when he suggested that "there might have been a time in our history when there were things in states that varied to a great extent, but then people moved from those states if they were unhappy with the way government was working" (Reagan, 1982).

Competition, Federalism, and Nationhood

The two ideologic positions that the Administration articulates involve the role of the market and the role of the federal government. The market's role in our lives is to be strengthened; the federal government's role in our lives is to be weakened. Both positions call for a redistribution of power and control. Thus, they reinforce each other for they can be considered twin

blades of a scissor designed to cut federal commitments. It is the perception of scarcity and austerity that calls for a scissor, as it is cynicism about Washington and a misreading of history that calls for the "New Federalism" and for the market. Other Presidents, after all, have called for a devolution of federal programs and responsibilities to the various states. Their efforts have not been especially successful. None, however, has had the advantage that Mr. Reagan has: his call comes at a time of perceived scarcity and is in tune, rather than at variance, with the attitudes held by a significant number of citizens--though, I hasten to add, it is not clear how many would agree with the specific measures advocated. General attitudes are one thing; specifics are quite another. The cost, after all, associated with general slogans, the translation of the general into specific, of slogans into programs, of principles into actions involving dollar transfers that we become aware of costs.

Though the Administration's motives may be ideologic and may be based on its antipathy toward government, its arguments advocating reliance on markets and on smaller units of government, on "competition," and "New Federalism" can be cast to appeal to a broad constituency. The arguments are part of our 200-year history, and it is therefore not surprising that they strike a responsive chord. "Competition in the market" suggests that each of us would be able to exercise greater control over the allocation of our individual monetary resources. The "New Federalism" suggests that decisions would be brought closer to home and, thus, that citizen involvement and control would increase. Both, therefore, can be made to sound like "Power to the People." But, of course, the redistribution called for would tie economic and political power more closely to the unequal distribution of income, wealth, and resources. How long a "power to the people" slogan remains appealing depends on the answers to the questions how much power? To which people? Over what?

There has been a long history of periodic attempts and failures to alter the evolutionary change in federal-state-local relationships. This history suggests that many voters as well as Chief Executives are thirsting for something that they believe existed in a simpler past. It also suggests, however, that these desires are nonspecific. Thus far, at least, important political, economic, and social forces have made it undesirable and/or impossible to translate the vague yearning into particular programs. The failure of past attempts, however, may provide relatively little guidance to future prospects. Given new marginalism, the Administration may find ways of combining the old yearning with a new awareness of scarcity and acceptance of existing inequities to accomplish that which others could not. While other Administrations spoke of new intergovernmental relations as desirable, this Administration can exploit the argument that they are necessary. The shift in emphasis from the political to the economic argument with its attendant sense of urgency may prove significant. Reorganizations based on a desire for neatness smack of aesthetics; reorganizations ostensibly forced by imminent "bankruptcy" may impel even those who doubt to accept the inevitable. The power of the idea and of its packaging must be reckoned with. The idea and variants thereof antedate and will outlive this Administration and its specific proposals. American attitudes, molded by our history and tradition, will keep questions of federalism and free markets on our political agenda. We must recognize that it is quite possible that important issues in

intergovernmental relations will, for some time, be discussed in the framework of a sorting out of programs rather than of coordination, cooperation, and a sharing of responsibilities within programs.

It is true, of course, that the growth of central power has reflected what has been termed "the coalescing into a national society; the advance of communications and transportation, the nationalization of the economy, and the sheer physical congestion of population. [These have] destroyed the isolation of states and communities" (Sundquist, 1969, p. 10). The creation of a complex national economy (including the growth of national firms) transformed the society and with it the view that its major problems were local in character. The depression, though played out in local areas, was a national problem. So, too, with problems of manpower training, local-area development, mass transportation, even education and law enforcement. But the national perception may be less powerful today than in the recent past. Those, for example, who have pulled up stakes, who have sought new opportunities, who have left the older cities of the North and have moved to the Sun Belt or to smaller urban centers and rural non-farms may prefer not to define the problems they left behind as national problems, as "their" problems, as requiring their contribution. The Youngstown steel worker made a personal decision to write off Youngstown when he sought work in Arizona. Will he pay taxes to support a national decision to save it? The fact that, in the past, mobility and a national perspective were not in conflict does not provide a clear answer for the present.

Attitudes change. It is perhaps no accident that the rapid expansion of the federal role outside the area of macroeconomics occurred at the very same time that the Civil Rights movements flourished, when integration was an expressed goal, and when "states' rights" were linked to bigotry and discrimination. Centralization and the downplaying of diversity and of differences coincided with the increased attention accorded the national Constitution. That we are all Americans--not white or colored, New Yorkers or North Carolinians--fit the then prevailing ethos. Franklin Roosevelt has emphasized national approaches to a national economic problem. The War had united a nation against common enemies. Lyndon Johnson, the Civil Rights movement, the Constitution emphasized the things we have in common. The new Administration, in contrast, takes office after a period of emphasis on heterogeneity; the rise of ethnicity--of Black, Italian, Jewish, Hispanic Power; of a war that pulled us apart; of economic growth in selected economic sectors and geographic areas and rapid decline in others; of special interest (not common interest) groups; of decline of unifying political parties. The Depression's Social Security System was universal. So, too, was Medicare. In contrast, many social programs of the 1960's, food stamps and Medicaid (and their expansion in the 1970's), served part--not all--of the population. "We and us" were replaced by "they and them," and the more so when economic growth slowed down and inflation accelerated.

A decline in federal financing, standard setting, and accountability cannot help but increase disparity and inequality between population groups, states, and regions (and, perhaps, especially between energy rich and energy poor areas). Many states, especially those which in earlier years were most supportive of medical care and other social welfare programs, face severe

fiscal problems as their personal and corporate tax base declines. The presence of disparity and inequality, even in health care, is hardly a new phenomenon. What is new, however, is the legitimization of outcomes that in an earlier period were considered unfair or inequitable. The Trojan Horse did enter the city, and the tax cut that provides special advantages to those who need it least was enacted. We learned that growth in inequality can be portrayed as part of the process of economic recovery and as only a small price to pay for "pie in the sky when you die." Even the strongest "safety net"--and what we have is being lowered and weakened--only keeps one from falling too far but not from falling. To speak of "safety nets" is to speak of a far different goal than that envisaged in the building of a "Great Society."

National perspectives and national programs involve redistribution. This is less painful and, therefore, easier to accomplish in a period of growth. But the economy is not growing and the national perspective competes with the personal; redistribution with individual needs; and sacrifice (unequally shared, at that) with the desire to hold on. It is, therefore, not surprising that there is a resurgence of the view that individual effort should provide solutions to problems which, even if widespread, are individual. New York and Cleveland are not the nation and, furthermore, New York and Cleveland seem to be making it after all. You, too, presumably could make it if you wanted to and read the help-wanted pages of the Washington Post. The call for the market--impersonal, abstract, guided by an invisible hand, built upon self-interest and competition--is the antithesis of government, personal, concrete, visible, and built upon collective interest and cooperation. If market solutions are viewed as optimal, it follows that government solutions are suspect. Competition calls for smallness, a situation in which no one is large enough to exercise control. In the drama called "competition," there is no role for the monopolist, most especially the federal government--so big and powerful that it is, as the President put it, able to "usurp" many of the activities it is engaged in. Our long-standing fear of bigness calls forth a fear of government as well as of corporate giants.

Nevertheless, it is far too early to assess how long the "New Beginning" will continue or how far it will carry us. This Administration, as all administrations, has multiple objectives, and its success or failure on one dimension will affect the probability of success or failure elsewhere. Thus, if its economic game plan works, its particular views on federalism and on the role of the market in health care will gain currency. The reverse is true as well. Indeed, even if the argument that we face broad social, political, and economic forces is accepted, it does not follow that the tide toward Administration's program of "New Federalism" is inexorable. Tides rise; they also ebb.

The trend away from a national perspective, perhaps from nationhood, is no more irreversible than the earlier trend toward "the dramatic expansion of the range of concern of the federal government," seen by one observer as "irreversible" and "the culmination of a historic trend--the final burial, perhaps, of traditional doctrines of American federalism that, for a long time, had been dying hard" (Sundquist, 1969. p. 6). In 1859, Chief Justice Taney wrote of "separate and distinct sovereignties." Nevertheless, Daniel

Elazar has suggested that even then, federal and state governments were engaged in cooperative federalism (Elazar, 1964). Certainly since then federal and state governments have shared rather than divided responsibilities. Notwithstanding the desire to return to a federal system characterized as a layer cake, we have, as Grodzins has put it, created a marble cake (Grodzins, 1960), and one that better suits the present and the future. It is not possible to impose neatness and simplicity on that which is inherently complex. There are problems whose character, magnitude, and pervasiveness call for national concern and whose solutions are so much in the national interest that the federal government is called upon to intervene. Furthermore, the federal government has broader revenue sources than do the individual states and local areas, and it can help compensate for imbalances in human and other resources. It can impose standards that, in a nation with migration, can prevent destructive inter- and intrastate competition to do less rather than more. The United States is one nation. It neither is or can be only an association of 50 sovereign states that have a defense pact and free interstate trade, some exquisite combination of the North Atlantic Treaty Organization and the European Economic Community.

Yet, even if we believe that that ahistorical construct, "New Federalism," is not likely to be enacted in the manner defined by this Administration, we would--as I suggested--be foolish to imagine that parts of it will not take root. Various elements (e.g., the substitution of block grants for categorical programs, a development that is not new to this Administration) do appeal to many Americans. The tension between the federal ability to raise funds, to define national problems, to move toward equal treatment under law for all Americans and state and local desire to administer (though not to fund) programs to deal with particular problems, needs and characteristics will remain. That tension will express itself in different ways in different fields and at different times. It cannot be eliminated by denying its existence just as it cannot be eliminated by devolution. Even the boldest redefinition of federalism, one at variance with American historical development and the nature of modern society, would continue to require cooperation and coordination between program administrators, levels of government, individuals in the field.

Whatever happens to "New Federalism," the issue of federalism will remain as part of America's continuing agenda and with it the need to discuss and refine concepts, programs, and responsibilities. The American concept of federalism has never permitted neat or stable classification schemes. It has been continually evolving. At least for the foreseeable future, there will continue to be a yearning for an image of a simpler past. It is because to do so may be good politics. It is important because programs do have multiple components (financing, planning, administration, accountability), and there is little reason to believe that all these can be carried out most effectively by the same level of government. Centralization of funding, power, and responsibility may be appropriate for some programs and for some activities; for others, however, there may be costs associated with centralization. Not the least of these costs is the perceived distance between the citizen and Washington. Just as it is important to be efficient and equitable, it is important to rebuild the sense of particpation, in some areas best achieved by emphasizing state and, especially, local control or responsibility.

In summary, then, we face a time of change. This Administration offers us a radical menu. It redefines federalism in ways that some of us believe does violence to the concept of one nation. These ideas do not derive their power from their substantive quality but from the fact that they can be cast in a budgetary framework at a time of economic crisis. This has made it possible to shift the dialogue from "coordination" to "devolution." While it is important to become more knowledgeable about the costs associated with the "New Federalism," it is also important to attempt to redirect the discussion to real issues. Such a redirection is not advocated in order to "meet the Administration halfway" but, rather, because it is clear that with a declining federal purse there will be changes in federal funding, program activities and responsibilities, and in the nature of federal-state-local relationships. It is to the questions of what those changes portend and how we might best deal with them that I now turn.

Responding to Change

"New Federalism" is a political program whose characteristics are not fixed. They change as the debate gathers force and as political pressures are brought to bear. Thus, it is impossible to attach a precise definition to what is essentially an evolving concept. In 1981, the Administration's thrust for new intergovernmental relations, for a restructuring of federalism, seemed to mean "consolidation" and was largely limited to "block grants." In his proposals in January of 1982, the President stressed his desire to transfer financial responsibility for Aid to Families with Dependent Children (AFDC) and the Food Stamp Program to the states and his willingness, in turn, to have the federal government assume financial responsibility for a constrained Medicaid program. He also proposed that beginning in 1984 states be permitted to "opt out" of some forty federal grant programs while continuing to receive dollars from a federal trust fund for those activities and that by 1988 the federal programs would end and the funding that accompanied them would be phased out over a four-year period. Thus, states which wanted to continue any of the various program activities would be required to finance them out of their own tax revenues. The 1983 budget also proposed various consolidations, e.g., the combining of Maternal and Child Health and Special Supplemental Food Programs for Women, Infants, and Children (while cutting authorized funding by $300 million). These various proposals have failed to elicit an enthusiastic response. They are likely to be revised, moving on from "new" to "newer" and finally on the "newest" federalism. Even so, it seems evident that "New Federalism" means, and is likely to mean, the elimination of categorical federal programs and their funding and/or the grouping of various federal activities into broad "blocks" supported by funding at reduced federal levels.

Since the 1981 block grant proposals were accompanied by significant cutbacks in appropriations and since the current proposals also contemplate reductions or even elimination of funding over a period of time, the discussion of the appropriate role for federal, state, and local governments has been contaminated by arguments concerning budget cuts. The various participants in the debate will not have the opportunity to discuss federalism as a set of principles or concepts concerning appropriate intergovernmental relations. They will necessarily examine it as it has been proposed, and it has been proposed in the context of federal-budget cutbacks. The rich

literature on federalism, the books we read as students, will be ignored. The argument will be about the transfer of responsibility and about dollar trade-offs. At one and the same time, the agenda will be about principles and about money (and especially about the latter).

In some circles in Washington, the "New Federalism" will derive its impetus and strength both from an ideologic bias against government and from the concept of austerity, from the feeling that something must be done to "save the federal budget." Yet, since the individual states and other interested parties will examine the state- and program-budget implications, "New Federalism" will also derive some of its weaknesess from those same dollar considerations. Proponents of a searching inquiry into issues of intergovernmental relations and those who favor a realignment of responsibilities will be disappointed that the debate will not be joined on what they see as the central issue but, rather, will degenerate into an argument over who will win and who will lose dollars. Their frustration will not be eased by the reminder that it was also thus with the nation's economic policy. There, too, the cause of responsible conservatism was ill served by the spirit of radicalism.

When debates involve both principle and money, it is the bookkeeper who dominates the discussion. It will not prove possible to debate the President's vision of the "New Federalism" on some lofty plane. Practical considerations, the impact on particular programs, will dominate. We will all be reminded of the "matter-of-fact man" of whom it was said: "Talk to him of Jacob's ladder, and he would ask the number of steps." Neither this Administration or the Congress will produce a new version of the Federalist Papers. Instead, the legacy to future generations will be sets of tables summarizing alternative fiscal impacts of various proposals. If the debate is about dollars rather than ideas, the compromise that will emerge is hardly likely to address important issues concerning the manner in which different levels of government might best cooperate to maximize the combination of efficiency, effectiveness, and equity.

Assumptions

We live in a world of uncertainty. We do not know what compromises will emerge; what the fiscal capacity of the various levels of government will be; what balance will be struck between mean spiritedness and generosity. The first step, then, in developing strategies for the next decade requires that we state our assumptions regarding likely outcomes of the "New Federalism" debate. Making these assumptions explicit may help sharpen the strategy discussion.

I shall assume, as has already been suggested, that the sorting out of the relationships between the federal government and states and local areas will remain on the American agenda whatever happens to particular proposals by this and subsequent Administrations. It is also likely that there will be a continuing effort to turn some programs over to the states and to fund others in a manner that increases the opportunity for state or local governments to shift some proportion of funds from one activity to another (an increased use of revenue sharing or block grants). The constraints on the federal budget

that are imposed by increased defense expenditures and tax reductions suggest that the sums appropriated for such revenue sharing or block grants will be reduced (perhaps in current but certainly in real dollars). Furthermore, the already enacted indexing of exemptions and tax brackets, will lead to continued constraints even after all the tax reductions have taken effect and even if there is a strong economic recovery. Unless indexing is repealed, fiscal dividends will no longer beckon from the horizon.

It is also reasonable to assume that the emphasis on and the rhetoric about the need for tax relief will discourage state and local officials from attempting to compensate for reductions in federal expenditures by increasing state and local tax burdens even as federal taxes are reduced. Though there will surely be some exceptions, most state and local governments will find their fiscal resources strained. The older industrial states will face a declining tax base. The growing states will see their economic expansion as linked to low rates. Finally, I anticipate that programs targeted solely toward those who are disadvantaged will have a low priority in state and local-area spending patterns. Buffeted by high rates of interest; requiring large sums to refurbish existing roads, bridges, water systems, sewers, and physical stock, and to maintain the present quantity and quality of public services (including public protection); needing revenue to support debt service and pension payments, states and local areas cannot be viewed as the levels of government that will be able to engage in significant redistribution. Nor, fearing that more dollars for the disadvantaged would only lead to the in-migration of more disadvantaged, will states and local governments be willing to emphasize redistributive programs.

Dismal as these various assumptions are, it should be noted that they do not represent the most pessimistic scenario imaginable. I have excluded major economic dislocations accompanied by significantly higher rates of unemployment than we already face; financial panic, collapse of the banking system or major declines in the value of pension-fund assets; continuing increases in bankruptcies and business failures. Nor have I considered possible destabilizing events in our political or international relationships. I note these exclusions in order to emphasize that the earlier assumptions are predicated on a certain continuity. Though depressing, they do not rest on an apocalyptic view of the nation or the world.

If things might be even worse, it is also true that they might be better. While it is not appropriate to assume that our present difficulties are simply a downward blip on an otherwise inexorably improving situation, that by 1985 we will be as we were in 1965 when unemployment averaged 4.5% and the Consumer Price Index rose by 1.7%, or that we will soon be willing again to commit ourselves to a War on Poverty, it is also not appropriate to assume that a downward trajectory is inevitable. Certainly it is impossible to achieve a social consensus to deal with crisis in an equitable manner when the Administration advocates policies whose impacts pull us apart. Surely, last year's fiscal policy did not call for equal sacrifice or provide equal benefits: upper-income groups gained and lower-income groups lost. Even if we accept the proposition that this policy was based on an economic-growth theory worth testing, the desired results have not yet been achieved. In the interim, however, social and economic disparities have widened.

Yet, it is not foreordained that future behavior be as harsh and inequitable as was the case in 1981. The reality of the economic crisis, after all, is not as severe and bleak as it appeared to be half a century ago. Whatever today's skepticism about the federal government's ability to act, the fact is that 1982 is not 1932 when people "did not expect government to do anything for them...[and] did not think that government could or should do anything for them. There was this enormous passivity under those hammerblows of the depression.... Our overwhelming occupation...[was] to persuade people to look to Washington for help. To convince them against the great weight of the American tradition that Government is the solution" (Beer, 1982). What Beer calls "the revolution in political expectations" did occur, although, it is also true that it did not eradicate the anti-federal-government strain, a part of our tradition. It may be optimism but it is not foolishness to hope that the sense of social purpose will again be articulated; that it will call forth our generosity and decency and alter our present expectations. I offer no prescription, but a reminder: "The fault, dear Brutus, is not in our stars, But in ourselves...."

But if policy, the range of options, should be not based on an apocalyptic view of the future, neither should it be based on an ostrich-like view of the present. What then are the options if my assumptions do prove right? What if there is a gradual cutback, sorting out, and even devolution of federal programs? What should we be about in the coming years?

Fiscal Issues

Let me separate fiscal issues from those involving coordination/standards/accountability/responsibility. The fiscal, though difficult to deal with, are easier to discuss--perhaps because they involve fewer options and are characterized by less flexibility. The constraints are clear. Whatever is to be done in the area of child health requires funds. There is little reason to suppose the services now provided through child health programs can be financed with fewer dollars. The system does not have that much waste or fat (and what it has cannot readily be eliminated since it is built into our institutional arrangements, into the way we have chosen to organize and reward our medical care system). Fewer dollars will inevitably mean fewer services per eligible child and/or fewer eligible children. Nor is there reason to suppose sufficient funds to maintain present efforts will be available if federal funding is withdrawn from child health programs or if we lump those programs into a block grant at a significantly reduced level.

Voluntarism cannot and will not generate sufficient dollars to mount private efforts at levels that would compensate for substantial cuts in government funding. Moreover, a high proportion of the dollars that will be generated through additional corporate giving will most probably be allocated to the arts and humanities, museums, universities, and other institutions that seem insulated from "political" considerations. At the same time, a high proportion of dollars generated through increases in individual giving are likely to be allocated to agencies that assist persons in most immediate need and to programs of an emergency nature: toward housing after a fire, food for the hungry, and activities that have an emotional appeal. It is true that such activities will help children with emergency and acute problems, but they are

far less likely to deal with prevention or chronic deficits, to offer comprehensive care, or to assist population groups as contrasted with individual cases.

Furthermore, such extra dollars as are generated by increased voluntary effort are likely to flow toward umbrella and private organizations with long-standing programs. Not only are these organizations best equipped to raise funds, but they make it possible for the contributor to transfer allocation decisions elsewhere and to feel more secure that the dollars will not be wasted or misspent. Thus, it will be difficult to mount new private activities designed to replace previously government-sponsored efforts and unless these new or expanded activities are undertaken by already established organizations or with the imprimatur of umbrella agencies. Voluntarism will help but will not help enough. It cannot substitute for government.

There was an earlier time when we might have looked to the medical community to provide free care for at least part of the population at risk. Perhaps that is what some expect of voluntarism. They will be disappointed. To be sure, individual physicians will respond, but the number of needy children, the costs of modern medicine, the new role of diagnostic technology and of the hospital preclude free care as a solution. Furthermore, the ethos of medicine and the attitudes of patients have changed as a consequence of society's decision to shoulder a collective responsibility. Free care no longer is an adequate or feasible alternative.

Nor will the states and local areas be able to use their limited taxing authority and tax base to compensate for federal funding. This would be the case even if the state of the national economy improved markedly. Certainly such improvement would increase state and local resources but being "better-off" does not mean being "well-off." The differences between the rich and poor states and the variation in state economies over the business cycle suggest that, even if there will be the will to take up the slack resulting from federal cutbacks, there will not be the way. States which are less vulnerable to cyclical change and whose economies are growing may be able to adjust to federal cutbacks but that will not be the general situation. Most states will find themselves hard pressed. Their fiscal difficulties will be especially severe during periods of economic downturn when they face the twin problems of expanding needs and declining revenues.

Over the last fifty years, much of the thrust toward centralization has derived from the recognition that states have only a limited ability to engage in deficit financing, and, thus, to compensate for declines in private sector activity and tax receipts. They cannot provide "automatic stabilizers" and cannot stabilize expenditures during unstable times. Thus, even aside from the unfavorable implications of the "New Federalism" on the speed and ability with which recessions might be contained and their impacts eased, it should be evident that a shift to an increase in state, rather than federal, financing of social services is likely to lead to large swings in the funding that is available. Such swings will not enhance program effectiveness or efficiency.

Of course, federalism need not be defined as a concept that requires substitution of state and local funding for federal appropriations. Certainly

that was not inherent in President Johnson's vision of "creative federalism" which emphasized "local (or state and local) programs, locally initiated and carried out, but brought into being and made possible by national leadership and national assistance" (Sundquist, 1969, p. 12). The Reagan Administration's proposals, however, are tied to the desire to cut the federal budget and to reduce the role of the federal government (and, I believe, of other levels as well). It presupposes that, if real effort is to be maintained, others substitute for the funding role played by Washington. The difference in the Johnson and Reagan formulation of federalism cannot be overlooked.

I cannot help but conclude that voluntarism and state resources will be insufficient to permit the continuation of child health activities at present levels of funding. The gap will grow even wider if, as is reasonable to assume, there is a declining Medicaid and AFDC commitment. The former would further reduce the ability of Medicaid to assist children, and the latter would further restrict the eligibility of children for Medicaid assistance. Child health programs and medical programs are more extensive than Medicaid and Early and Periodic Screening, Diagnosis and Treatment (EPSDT). Focusing on the Administration's Medicaid proposals, therefore, provides an incomplete picture of the manner in which the health of children would be affected. Account must be taken of medical services supported and assisted by other programs and of nonmedical programs that affect health, e.g., nutrition, housing, income-maintenance. Thus, child health would not fare well under the "New Federalism" even if Medicaid were not to suffer. Reductions in Medicaid would add to the difficulties.

It is inevitable that under "New Federalism" fewer dollars will be available and fewer children will be assisted. Furthermore, there is a high probability that the dollars will buy fewer services. The rate of inflation in health care costs continues to be high. Yet, for a year or more the Administration was so taken with developing its competition program (designed to restructure the health care system by reducing third-party payments and by increasing awareness of medical care costs) that it continued to ignore inflation in health care costs. It is true that the Administration believed that, in the longer run, its attempts to "restructure" the health sector would succeed in stemming the inflationary spiral in health care costs. Yet, no one could reasonably expect that this would occur quickly (if it occurred at all). Time and space do not permit an extended discussion of the "competitive approach" and its implications for the health of children. Yet, even if one were optimistic--and I am not--that the competitive solution would not do violence to equity, it would still be true that in the short and intermediate run health care inflation would continue. It now appears that the Administration has pulled back from its proposed solution. It is not clear, however, whether and how it will choose to deal with inflation. The scarce dollars available for child health care are likely to continue to buy less and less. More than that: as long as there is rapid inflation in overall health care costs, children's programs (even if they are only a small part of health care expenditures) will suffer. They will be addressed in the context of rising expenditures and will be viewed from the perspective of competition for scarce health dollars. There is no escaping the fact that the way child health programs are viewed is, in part, dependent on factors exogeneous to child health, e.g., on costs of hospital care for the elderly.

High on the agenda for child health care advocates, therefore, must be a continuing effort to press for legislation that preserves federal funding and that attempts to deal meaningfully with inflation in health care costs. We must press to protect services for children because children have special needs and characteristics. On average, meeting their medical care needs is not especially costly and has a high pay-off. Failure to meet those medical care needs--and the even more extensive health needs--may carry life-long implications. The case for prevention and health promotion is clear and the efficacy of various interventions (e.g., immunization, nutritional care) well documented (Select Panel, 1981, Vol. 1, pp. 1-21). Furthermore, children are especially vulnerable. In 1976, 14% of all children under 6 years had no private or public health care coverage; another 17% relied on public programs. Children under 6 in families with income under $5,000 fared even worse: one-fifth had no health care coverage and almost 70% had only public coverage (Congressional Budget Office, 1979). An agenda that relates to dollars does suffer from the fact that it sounds--and is--"old-fashioned." Yet, we cannot rule it out on those grounds alone. Dollars are a prerequisite. They may not be sufficient, but we cannot behave as if they are unnecessary. Children's opportunities to obtain care rest on many factors. Surely, however, the public programs and the funds that enable them to function are critical.

Child health advocates must continue to emphasize the special characteristics of children and of the medical care services they require. Yet, even as they do so, they will have to undertake new activities and seek out new allies. Child health advocates can no longer assume an expanding resource base and federal commitment. Thus it is no longer sufficient to concentrate on obtaining a fair share of a growing pie. Child health advocates will have to become more knowledgeable about how the resource base is created and maintained and more concerned about the nature of the various federal expenditures and commitments, i.e., about tax policy, defense expenditures, social programs, economic growth. They will have to express their point of view on income-maintenance programs, Medicaid, and the organization of medical care, as well as on EPSDT, and Maternal and Child Health Programs, and the Supplemental Food Program for Women, Infants and Children. I believe it is critical that child health advocates join with others whose concerns may help determine the context in which child health policy will be formulated and will function. Those others may not see child health programs as their priority. They may spend their time and effort on other "micro" or on "macro" issues. Yet we must act upon the recognition, already noted, that child health is part of the health sector, the health sector is part of the total economy and society. Those who support other micro social service programs also contribute to health. Those who would advance the "macro" help in making possible changes at the micro level. This is hardly the time for any of us to be parochial.

Organizational Issues

The fiscal dimensions of the agenda are designed to preserve the funds required to do the job. Other parts of the agenda, however, accept the need for change. The pressures for a more precise sorting out and sharing of the responsibilities of various levels of government are real, and it is necessary to respond to that reality. How the desire for a different functional division of intergovernmental responsibilities will be addressed by the Congress is, of

course, not clear. Four hundred and thirty-five members of the House and one hundred members of the Senate will not be satisfied simply to determine the formula that tells the Treasury where to mail checks. They want to be involved in programs and welcome the benefits that accrue from announcing the grant for the bridge and the neighborhood health center, especially so if they must bear the costs of legislating taxes. Yet, though the outcome is unclear, the fact that there will be a debate on intergovernmental relations means that there is a need to rethink existing patterns. There is an opportunity to respond creatively to the apparent increased desire for local decision making. Some of us may believe that, in fact, national programs did accommodate themselves to the diversity that is America. The rhetoric about the lack of flexibility imposed by central government on activities carried out at the local level does not adequately describe reality. Indeed, in many cases the federal government simply transferred funds and relied on the states for monitoring activities and the drafting and enforcing of rules and regulations. Furthermore, most citizens would be as disturbed at the absence of rules and accountability as they may seem to be about their presence. Nevertheless, the rhetoric about the federal government as intrusive and onerous has affected public perception and that, too, is reality. Thus, the debate on federalism presents a need and an opportunity to again address the fact that much of the health policy that determines the level of expenditures is formulated locally and that health services are organized locally. The various states and local areas have different needs and different levels of capability. It is appropriate, therefore, to again consider which functions appropriately belong to the federal government and which to other levels.

I have suggested that the responsibility for major funding of child health programs must continue to rest with the federal government. It and it alone is able to raise sufficient funds and take account of the economic disparities between the various states and their populations. As a consequence and in recognition of the diversity among the states, the federal government is the appropriate locus for the setting of broad goals, objectives, and standards. It is true that there are those who argue that such federal "intrusion" is inappropriate on the grounds that citizens of the various states or localities should determine what they would do with revenue sharing or block grant funds. They suggest that there is little reason to believe that the Congress is wiser or knows better than do the citizens of Peoria or San Jose, Boston or Mobile how <u>they</u> should spend <u>their</u> money. They contend that to impute more wisdom to Washington smacks of the same elitism that is found in arguments for welfare assistance in kind rather than in cash (why give the poor Medicaid insurance, why not provide money which the recipient can spend as he or she sees fit). Whatever the merits of the argument of transfers in cash rather than in kind, the analogy does not hold.

The sums made available by the Congress are not for San Jose or even for all the citizens of San Jose. They are appropriated and made available to benefit <u>some</u> citizens. The federal government is not simply an efficient tax collector raising dollars for San Jose on the basis of a contractual arrangement to do so returning to San Jose the sums it collects from and for San Jose. The federal tax is not a San Jose tax which is collected by the Internal Revenue Service. One could imagine such a relationship but that is not the one that obtains. Thus, the federal government uses <u>its</u> tax revenue and

redistributes some of it by sending money to areas on the basis of its assessment of their needs and resources. Washington may not be wiser than the citizens of San Jose about the purposes for which they tax themselves and for which they should spend their money, but it is acting in accordance with its responsibilities if its set guideposts on how funds collected from all parts of the country should be allocated. Perhaps target populations are wiser than Washington about what programs would maximize their benefits, but "New Federalism" does not call for target-population control. It is based on inter-governmental relations and presumes that state and local governments are wiser than Washington about how best to assist parts of their population. There is no evidence to suggest that that presumption is correct. Indeed, there is historical evidence that it is false. It is that evidence, the fact that states could not and/or did not respond adequately to the needs of their poor and politically voiceless citizens, that led to Congressional action and the development of federal programs.

Regrettably, the assumption that greater local control will lead to greater involvement by all citizens in government affairs--a virtue in its own right--and, presumably, as a consequence, to better decisions--a further virtue--remains an assumption. The accuracy of the assumption does not hinge on competence, though that is an important question. Rather, its accuracy hinges on political power and its distribution. There is ample reason to believe that, even in spite of its performance in 1981 and even with all its shortcomings, the federal government is more likely to heed equity considerations. Surely citizen participation is a worthy goal. It may even be so important that the potential cost of poorer decisions that might occur while all of us learn to participate is worth bearing. But it is not evident that turning dollars over to state governments would increase particpation. Our states are large; so are our cities and that is where the problems are. It is not helpful to conjure up the image of the town meeting in Concord, MA (and a possible false image at that) when the problems are in Boston. Furthermore, many citizens do prefer to turn over responsibility to others in order to spend time on their priorities. Representative government developed for good reasons and these still hold. We dare not base public-policy decisions, especially those that would negate and radically reverse historical processes and developments, on wish, fantasy, myth, and nostalgia.

Finally, it should be noted that a society may, in fact, be strengthened by the transfer of decision making and of conflict to a more distant plane, to a higher level of government. There is a price associated with closeness and proximity: debate can become more strident and conflict more intense. The civility that we impute to the small town often extended only to people of like mind and color. Those who felt or behaved "differently" were not ignored; they were harassed.

It is not only reasonable but necessary to seek federal goals, standards, and arrangements for accountability. On average, they will be helpful. Yet, there will be cases where this may not be true, federal standards will be constraining and confining, where--if program goals are narrowly defined--federal priorities may be inappropriate. Surely, as in other areas of human activity, the quest must be for balance. Broad goals can be subverted, narrow goals inappropriate. There is no formula that defines the optimum arrangement.

That is why, in recognition of the need for flexibility as well as the need for protection, I earlier used the word federal "guideposts" rather than "guidelines." It is reasonable to permit local governments (especially large cities) to shift a proportion of funds (say, perhaps 10 to 20%) between various program activities aimed at the same target population. Such shifts, however, should be subject to procedural constraints and approval. They should also be part of a longer range plan, thus preventing large, rapid, and destructive fluctuations in funding. Multi-year planning and even funding can be designed to lift the cloud of concern and fear of instability that inhibits those who deliver and those who receive services from directing their full attention to planning, developing suitable infrastructures, and building intermediate and even long-range capabilities.

In addition to advocating an increased flexibility in the proportion of funds to be allocated at the local level (and in state programs), it is appropriate to provide for greater latitude and flexibility in program development and implementation. The federal government should emphasize the goals to be reached. It should monitor the degree to which they are attained and hold other levels of government and those who organize and deliver services accountable. It should, nonetheless, permit the various states and local agencies to develop their own ways to reach those goals. There is no reason to believe that procedures, methods, and organizations that are appropriate in one locality will be equally so in others. Resources, traditions, cultures differ. The freedom to innovate, to do it "our way" but to do it, is important. It permits people to take pride in their accomplishments. That is surely more rewarding than the pride generated by success in following directions. Such freedom should be sought and its potential benefits recognized. Rewarding exemplary performance is as necessary in the provision of social services as in other endeavors, and mechanisms that provide freedoms, stimulus, and rewards need to be developed.

The argument for latitude at local and state levels can be buttressed by considering the record of local and state endeavors in various health sector activities. In a number of activities, such as planning, rate setting, budgeting, and other elements of cost control, various states have led the federal government. Indeed, it is not unimportant to note that a number of states have emphasized cost control while federal authorities have been concerned with expenditure control. The former calls for programmatic efforts; the latter calls for expenditure cutbacks. A number of states and local areas have organized the delivery of services in an imaginative and responsive manner, building on local constituencies of citizens who know and care about the programs. The states, of course, are not equally capable, but it is fallacious to suggest that none of them are able to do more than follow a federal cookbook.

Gathering and Diffusing Information

A decentralized program activity will require accountability and the collection of data and information. The need for data on which to base decisions is not negated by alternative intergovernmental arrangements for program planning, development, and administration. It cannot be assumed, however, that the resources needed for data collection and analysis will be

available. Information is not likely to appear as a high priority item in strained budgets. Already one finds the federal effort in data acquisition and analysis being cutback. Child health advocates, aware that their case is buttressed by data on the special and unmet needs of children, as well as on the efficacy of various interventions, will have to press for the collection and analysis of information without which "accountability" and "responsible decision making" are empty terms.

One of the difficulties with state and local efforts--a difficulty we face even at the present time--is that of dissemination of information. Thus, innovation spreads slowly or not at all. Today, the assumption is that federal employees can monitor state activities and, noting the success stories, diffuse that information. The general validity of that assumption is not clear. Surely, it varies between programs and is dependent on a variety of factors. Yet, it is likely that issues of competence and of knowledge may be even more serious in a decentralized system. The "cookbook" may be stifling to some, but not everyone can function without it. If we move to greater flexibility at state and local levels, it will be necessary to be far more concerned with these diffusion issues. It will be vital to develop ever more effective mechanisms to share information, findings, evaluations, and reports. With the reduction in federal funds and in federal advocates for and employees concerned with child health programs, private efforts to encourage and mount information-sharing activities will be essential. It is unlikely that state and local governments will allocate sufficient resources to this effort. Conversely, it is something that can be done through private initiative and university involvement.

In a period of greater decentralization, it will also be necessary to share information on a new range of "topics." There will be a need for national or regional organizations designed to help develop specific program goals and ways of reassuring their attainment and to help citizen groups to conduct effective lobbying, influence decisions and decisionmakers, and to monitor developments. Previously the focus of such activities was the federal government. Its retreat requires the development of alternative ways in which some of the various responsibilities that government once met can continue to be addressed. Its retreat also means that citizen efforts once directed toward Washington will have to be directed at 50 state capitals. The organizations designed to "make their case" will, necessarily, have to spread across the nation. If programs are decentralized, so too with private organization counterparts. In creating new institutions or assigning these new tasks to already existing organizations, there will, regrettably, be waste and inefficiency. There will, however, be ample opportunity to build citizen involvement and participation, the need for which, presumably, is one of the goals of "New Federalism" (or, in any case, one of its rationales).

It is necessary to adjust to the distinct possibility that many critical policy decisions regarding child health programs will be decentralized away from the federal level. The responsibility for major elements of funding will, of necessity, remain in the federal budget. This will be especially the case with Medicaid. Nevertheless, a greater measure of responsibility for the allocation of funds, program mix (especially outside of Medicaid), definition of eligibility, and other programmatic features will devolve onto the states.

If that is the case, it will be imperative to broaden the base of involvement and understanding far beyond that which exists today. I believe that there are many Americans (even aside from those who are directly assisted) who do care about improving child health, but that a high proportion do not know about the various programs, lump them together with "welfare" and under a heading called "big government." Few know what needs to be done to further the health of children; even fewer known what is already being done (and with what success). The support of these individuals is required and can be mobilized if child health advocates tell their story in specific terms. The different public reactions to cutting welfare, cutting the school lunch program, and calling ketchup a vegetable are indicative. "Helping the needy" still ranks high, even as "providing welfare" ranks low. If elements of the "New Federalism" fare well in the political debate, it will be necessary to build upon and broaden this base of citizen support for child health programs. Indeed, that agenda is valid regardless of how the "New Federalism" fares.

Agenda for Action

The reader will have noted that I have not developed a strategy by which privately sponsored and funded programs in the child health area can substitute for government efforts and government funding. Neither have I suggested a strategy by which we might achieve a better financed child health care system under a program of social insurance. The former is not possible; the latter cannot be attained at present. The paper, therefore, offers little comfort to those who would assume that, since there is a problem, there is an implementable solution.

Nevertheless there is an agenda for action. There are things to be done and they are doable. Many who attend this conference are already engaged in efforts to increase program effectiveness within the new constraints. Those efforts will take energy, time, and commitment. Yet, important as they are, they are not enough. More is required. Let me, therefore, focus this concluding section on an additional task before us: the need for action designed to alter the constraints under which we operate.

1. If the children are to be served, it is necessary that those whose agenda is child health make common cause with others whose priorities and program interests are somewhat different but whose efforts are consistent with a child health agenda. Some of these allies will be directing their efforts at other and broader medical care and health issues or at nonmedical care social programs. Other allies will be found among those who deal with tax and expenditure policies and whose energies are directed at stimulating economic recovery while maintaining a commitment to equity. Yet, seeking out those who would work with us is not enough. It is necessary that we work with them, and to do so in an effective manner requires that we understand the issues. Their agenda is our agenda--if we choose, as we should, to define child health in broad terms. Those who fight for an improved economy are fighting for child health directly and for conditions which permit enhanced child health policies. Child health advocates cannot ignore income-maintenance programs or tax and expenditure policies on the grounds that such matters are outside their field of interest or expertise. Our interests must be catholic, and no one is more expert than the people on the values we hold and the choices we would make.

2. It is necessary that we work to alter public perceptions and attitudes about government and to increase the public's understanding of the role that, in our society, only the federal government can play. I do not minimize the difficulty of this task. Americans are not likely to have a love affair with government. But, perhaps, we can move things a bit and reduce some of the antipathy that makes it almost impossible for government to work effectively. Those committed to child health need to emphasize that the fact that some government programs fail does not mean that they all must do so; that the new scarcity does not require the abandonment of the goal of greater equity; that assistance to those in need requires action at the federal level. We must explain the necessity for rules and regulations that enhance effectiveness and assure accountability, the importance--but insufficiency--of voluntary efforts, and the implications of the differences between federal, state and local tax structures. Americans do remain concerned about the needy, about children, about medical care. The task, therefore, is to explain that those concerns cannot be met except through federal action.

3. Medical care for children is part of the larger medical care sector. How children's care is delivered, what it emphasizes, and what it costs are not independent of that larger sector. Persons interested in child health must, therefore, address such issues as support for health maintenance organizations, expansion of primary care, and of social-support services. They must also become involved in efforts to contain and control health care costs and expenditures. The control of health care costs cannot be accomplished by using Medicaid or Medicare as levers with which to move the medical care system. Yet, unless we succeed in involving all those who fund care in cost control, the burden will fall on public programs and the populations they serve. Little good will be achieved but many individuals, including children, will be hurt. If we are convinced that cutting eligibility and services, that reducing the availability of insurance coverage, that rationing through market prices are methods that would reduce equity, we must suggest alternative approaches. Thus, we are called upon to support rate setting, health planning, prospective budgeting, utilization review, new reimbursement policies, and other such measures. We must do all we can to create new incentives and to encourage state as well as federal efforts in these various areas.

4. We cannot assume that all these various efforts will bear fruit rapidly, but we must assume that over time they will succeed. It is, therefore, required that we begin the process of preparing our agenda for the future. To postpone that effort is to run the risk of missing opportunities. Where will those concerned with child health programs stand on the issues of tomorrow: the role of the federal government and of the states; means-tested or social insurance; direct provision of services or third-party payment programs; special programs for needy children and pregnant women, universal programs for all children and pregnant women, or programs covering the entire population; phasing in of benefits or of population groups in any expansion of medical coverage. Surely there will be those who argue that these issues do not require speedy resolution. That argument should be rejected. It is not too early to be concerned about tomorrow's children. Nor is it too soon to sketch the outlines of what we would like that future to be. There will come a time when we will be asked what we stand for. We must be prepared to answer.

5. General as these agendas designed to alter the constraints that press upon us are, those concerned with child health must also act on the specific. They must function with increased effectiveness in today's setting. They will have to diffuse information about the health status of children, about effective programs, about the benefits of intervention. They will have to develop mechanisms to monitor and influence that way block grants are administered, to expand technical assistance and training efforts, to gain citizen support and involvement. For some of us, these efforts at the state and local level will be new and difficult, but it would be irresponsible to wring our hands wishing it would be otherwise.

Many of the efforts I suggest are needed--are variations on old themes with which we are all quite familiar. This should not surprise or disappoint us. There is a need for continuity even as there is a need for change. Some of the old answers still apply because some of the old questions and values still remain: how to build a more equitable, cohesive society; how to share our burdens and divide our product. In searching for those answers, those interested in the health of children are part of a more general struggle. How they fare depends in part on their behavior, but it depends as well on how others in other sectors rally their forces.

Thus, even as we do things that we have done before--lobbying, organizing, educating--and even as we attempt to retain as much funding as possible while adjusting to and taking advantage of new organizational realities and possibilities, and even as we try to build voluntary organizations at the local level, we must search for allies who are fighting on other fronts. Health involves more than medical care and children have many needs. The battle against discrimination, for better education and housing, for a more rational income-support system, and for a stronger economy which distributes its fruits more equitably is also part of a health program for children. That, too, is not a new answer. "Organize" is an old slogan. But it remains valid. If it is social consensus that we seek, we can best begin by building that consensus with our natural allies.

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